

The State Health Plan

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Valuable Benefits

The purpose of the State Health Plan is to provide you and your dependents with valuable medical coverage if you become sick or injured. With the Plan, you have extensive coverage when you need it the most.

The State Health Plan is a self-insured medical plan. Because we are self-insured, we design the Plan's coverage and benefits. We do not pay premiums to an insurance company. Your monthly premium, combined with all premiums collected and the state's contribution, is placed in a trust account maintained by the state to pay claims and administrative costs. Any interest earned from this trust account is used to help fund the Plan.

In 2004, the State Health Plan projects to pay approximately \$1 billion in claims for its subscribers. To administer the Plan, we have contracted with third-party claims processors, such as BlueCross and BlueShield of South Carolina to pay medical claims, APS Healthcare, Inc., to pay mental health and substance abuse claims and Medco Health Solutions, Inc., to pay prescription drug claims. Less than four percent of our budget goes to pay these third-party claims processors.

The following is an abbreviated description of the State Health Plan. To make locating information easier, this section has been divided into 10 major components:

- ❖ Enrolling in the Plan
- ❖ The Plan at a glance (how the Plan works)
- ❖ General benefits
- ❖ Preventive benefits
- ❖ Prescription drug benefits
- ❖ Mental Health benefits
- ❖ What services are not covered
- ❖ How to file claims
- ❖ When coverage ends

The Plan of Benefits document contains a complete description of the Plan. Its terms and conditions govern all health benefits offered by the state. If you would like to review this document, contact your benefits administrator or the Employee Insurance Program.

Enrolling in the State Health Plan

Initial Enrollment

If you are an eligible employee (see definition on Page 220) of a participating entity of the state of South Carolina you can enroll in the Plan within 31 days of the date you are hired. To enroll, you must complete the required forms, including a Notice of Election (NOE) form. Coverage is not automatic. You can also enroll your eligible dependents.

After you enroll, you should check your payroll stub to make sure your payroll deductions agree with the benefit level selected. Your coverage will continue from one year to the next as long as you are a full-time, permanent employee. Your coverage begins on the first day of the calendar month coinciding with or following the date you begin employment and are actively at work. Coverage for your enrolled dependents begins when your coverage becomes effective.

Late Entry

If you do not enroll within 31 days of the date you begin employment, you cannot enroll yourself and your dependents until the next open enrollment period or within 31 days of a special eligibility situation (see definition on Page 225). Open enrollment is held every other year. The next open enrollment will be held in October 2005 for a Jan. 1, 2006, effective date.

Changing Plans

You can change from the Economy plan to the Standard plan or vice versa only during the enrollment periods. There may be exceptions to this rule. Contact your benefits administrator for details.

Marriage

If you wish to add a dependent spouse and/or child because you marry, you can add him by completing an NOE within 31 days of the date of marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is or he becomes eligible for coverage as an employee or retiree of a state-covered entity (exceptions may apply). If you do not add him within 31 days of the date of marriage, you cannot add him until the next open enrollment period (or within 31 days of a special eligibility situation).

Divorce

If you divorce your spouse, you must drop him from your coverage by completing an NOE within 31 days of the date the divorce decree is signed, unless you are legally required to cover him by court order or the terms of the divorce decree. Your divorced spouse's coverage ends effective the last of the month in which the divorce decree is signed. If you remarry, you can cover your divorced spouse, if mandated by court order, or your current spouse, but not both.

You can continue to cover your children if they live with you and you are financially responsible for them, or if you are legally required to cover them. Dependents who lose coverage may be eligible to continue coverage under COBRA. Contact your benefits administrator or EIP within 60 days of the loss of coverage for details.

Adding Children

Eligible children may be added by completing an NOE within 31 days of the date of birth (notifying Medi-Call of your baby's delivery does not add that baby to your health insurance), gaining custody, adoption or placement. Children must be listed on your NOE to be covered by the State Health Plan. When you gain a new child, you must list that child on the NOE, even if you have family coverage already. If your spouse is also a state employee, only one of you can cover your children.

If your child is **not** a full-time student, his eligibility for coverage ends the last day of the month in which he turns age 19, unless he is covered as an incapacitated dependent. Your dependent child's eligibility for coverage also will end if he gets married or obtains employment with benefits.

Full-time Students

You can cover your dependent children ages 19 through 24 who are full-time students. To cover your dependent children who are full-time students, they must meet the following eligibility requirements:

- ❖ Students must be enrolled and attending an accredited high school, vocational/trade school or college/university *full-time*, as defined by the institution they attend.
- ❖ While summer school is not required for maintaining student status, dependents who enroll in summer school full-time may become eligible. However, they may subsequently lose eligibility if they do not maintain their full-time student status the following semester/quarter.
- ❖ Adult education night classes and correspondence courses do not constitute full-time attendance.
- ❖ Students may no longer "sit out" a semester, trimester, etc. (excluding the summer), and maintain insurance eligibility. It will be your responsibility to notify your benefits office that the child no longer is a full-time student.

EIP will send a Student Certification letter to your benefits administrator approximately 90 days before your dependent's 19th birthday. This form letter must be completed and returned to EIP within 31 days of the child's 19th birthday, along with verification of student status (on letterhead) from the institution. Failure to return the form will result in the termination of coverage for your dependent child. If the child's 19th birthday occurs during the summer months, you should select the pending status option on the Certification letter, return it to EIP and submit verification from the institution by October 1.

If your ineligible dependent, age 19-24, regains eligibility by returning to full-time student status, you may re-enroll him by submitting an NOE form, along with a verification of student status (on letterhead) from the institution, within 31 days of eligibility.

If your child is covered as a full-time student, his eligibility for coverage automatically ends last day of the month in which he turns age 25, unless he is covered as an incapacitated dependent. It will be your responsibility to notify your benefits office that the child no longer is a full-time student. If you fail to notify EIP of a dependent age 19 through 24 who is no longer eligible for coverage you may

be subject to penalties if the dependent was not dropped from coverage when he became ineligible. Contact your benefits administrator for details.

EIP conducts random audits of enrolled dependents ages 19 through 24. If you fail to verify your dependent's student status, this will result in termination of an ineligible dependent's coverage and may result in recoupment of benefits paid on behalf of the ineligible dependent.

Incapacitated Child

You can continue to cover your child who is age 19 or older if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet the following eligibility requirements:

- ❖ The child must be covered at the time of incapacitation.
- ❖ The child must be unmarried to be eligible and must remain unmarried to continue eligibility.
- ❖ The child must be incapable of self-sustaining employment because of mental illness, retardation or physical handicap, remaining principally dependent on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.
- ❖ The incapacitation must be permanent.
- ❖ Incapacitation must be established within 31 days of the child's 19th birthday or within 31 days of loss of full-time student status.
- ❖ An Incapacitated Child Certification Form must be completed by both the subscriber and the attending physician and then forwarded to EIP for review.
- ❖ EIP may from time to time request an incapacitation verification.

Gaining Other Coverage

If you or your dependents gain other group coverage, you have 31 days to make a coverage change by completing an NOE and returning it to your benefits office with proof that coverage has been gained. If you fail to make a coverage change within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

Loss of Other Coverage

If you or your dependents are covered under another health insurance plan and you lose that coverage **involuntarily** because it was discontinued or the covered employee left employment, you have 31 days from the last day of coverage to enroll in the Plan. To enroll, you must complete an NOE and return it to your benefits office with proof that the health insurance was discontinued. Dependents must also be listed on the NOE in order to be covered and the documentation of loss of coverage must indicate who was covered. If you fail to enroll within the 31 days, you must wait until the next open enrollment period (or within 31 days of a special eligibility situation) to enroll in the Plan.

Your Plan at a Glance

	Economy Plan ¹	Standard Plan ¹
Annual Deductible	\$500 Individual \$1,000 Family	\$350 Individual \$700 Family
Per Occurrence Deductibles:		
Emergency Care	\$125 (waived if admitted)	\$125 (waived if admitted)
Outpatient Hospital	\$75 (waived for dialysis, routine mammograms, routine pap smears, clinic visits, ER, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits)	\$75 (waived for dialysis, routine mammograms, routine pap smears, clinic visits, ER, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits)
Per Office Visit Deductible:	\$10 (waived for routine pap smears, routine mammograms and well child care visits)	\$10 (waived for routine pap smears, routine mammograms and well child care visits)
Coinsurance²		
In-network	You Pay 25%; State Pays 75%	You Pay 20%; State Pays 80%
Out-of-network	You Pay 45%; State Pays 55%	You Pay 40%; State Pays 60%
CoinsuranceMaximum³	\$2,000 Individual \$4,000 Family	\$2,000 Individual \$4,000 Family
LifetimeMaximum	\$1,000,000 (one million dollars)	\$1,000,000 (one million dollars)

This is a brief overview of your medical plan. The Plan document governs all health benefits offered by the state.

¹There is a \$200 penalty for each medical hospital admission that is not certified or precertified by Medi-Call. For any mental health or substance abuse services not precertified or preauthorized by APS Healthcare, no benefits will be paid. Failure to call Medi-Call during the first trimester of pregnancy or refusing to participate in the Maternity Management Program will result in an additional penalty of \$200 for each maternity-related hospital or skilled nursing facility admission, including delivery.

²There are different coinsurance amounts for infertility treatments and prescription drugs. The lifetime maximum benefit for infertility treatment is \$15,000.

³Prescription drug copayments, emergency room, outpatient and office visit deductibles do not apply to medical coinsurance maximum.

Deductibles and Coinsurance

The two available State Health Plan options are the Economy plan and the Standard plan. Both plans offer comprehensive coverage with preventive care features and the most participating providers in the state. Regardless of which option you choose, it is important that you understand how your plan works. Prescription drug benefits are the same regardless of the plan selected (see Page 28).

Annual Deductible

The annual deductible is the amount of covered expenses (including mental health and substance abuse expenses) you must pay each year before the Plan begins to pay benefits. The annual deductibles are:

Economy plan	\$500 for individual coverage \$1,000 for family coverage
Standard plan	\$350 for individual coverage \$700 for family coverage

Keep in mind that the family deductible is the same regardless of how many family members are covered. For example, if you have the Standard plan family coverage, once any one person has paid the \$350 individual deductible, he will begin receiving benefits and the \$350 will be applied to the family deductible. No one family member may pay more than \$350 toward the \$700 family deductible.

For the other family members to begin receiving benefits, either their individual \$350 deductible, the \$700 family deductible or a combination of individual deductibles totaling \$700 must be met. For example, if four people each have \$175 in covered expenses, the family deductible has been met, even if no one person has met the \$350 individual deductible.

In order for the employee and his spouse covered as an employee, to share the same plan family deductible, both spouses must select the same health plan.

Per Occurrence Deductible

This is the amount you must pay each time you have an emergency room or outpatient hospital service before the Plan begins to pay benefits. It does not apply to the out-of-pocket maximum.

The deductible for each emergency room visit is \$125. This deductible is waived if you are admitted to the hospital.

The deductible for each outpatient hospital service is \$75. This deductible is waived for dialysis, routine mammograms, routine pap tests, clinic visits (an office visit at an outpatient facility; for an outpatient facility claim that is filed with a psychiatric diagnosis to be covered, the facility must participate in the APS network; clinic visits are not covered if filed with a psychiatric diagnosis), emergency room, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visits.

Per Visit Deductible

This is the amount you must pay each time you go to the doctor before the Plan begins to pay benefits. It does not apply to the out-of-pocket maximum. The deductible for each doctor visit is \$10. This deductible is waived for routine pap smears, routine mammograms and well child care visits. Here's an example of how the per visit deductible works:

- ❖ If the SHP Standard plan allows \$47 for a physician's visit, you would first pay the \$10 per visit deductible. Then, if you have not met your annual deductible, the remaining \$37 would apply toward meeting your annual deductible. Your total bill would be \$47 ($\$10 + \$37 = \47).
- ❖ If you have met your annual deductible, the Standard plan would pay 80 percent of the \$37, or \$29.60, and you would be responsible for the remaining \$7.40. Your total bill would be \$17.40 ($\$10 + \$7.40 = \17.40).

Coinsurance

After your **annual** deductible (per occurrence and per visit deductibles still apply) has been met, the SHP pays a portion of your covered medical and mental health and substance abuse expenses, either 75 percent for the Economy plan or 80 percent for the Standard plan, and you pay the remaining 25 or 20 percent. These payments are called coinsurance. The amount you pay contributes to your coinsurance maximum.

A different coinsurance rate applies for infertility treatments and prescription drugs associated with infertility (see Page 18).

Any charge over the Plan's allowable amount for a covered medical expense is your responsibility if you use a non-network provider. You will also be subject to a 20 percent out-of-network differential (see Page 16). This means the coinsurance for non-network providers is 55 percent for the Economy plan and 60 percent for the Standard plan. If you use a non-network provider for mental health or substance abuse services no benefits will be paid without authorization from APS Healthcare.

Coinsurance Maximum

The annual maximum amount you must pay in coinsurance for either the Economy or Standard plan is \$2,000 for individual coverage or \$4,000 for family coverage. The SHP will then pay benefits at 100 percent of the allowable amount. This limit does not include expenses for non-covered services, prescription drugs, the annual deductible, per occurrence and per visit deductibles or penalties for not calling Medi-Call and APS Healthcare.

Lifetime Maximum

The maximum amount the Plan will pay for each person in his lifetime is \$1,000,000. This maximum applies to the Economy, Standard and Medicare Supplemental plans and any combination of benefits under these plans.

Provider Networks

Preferred Provider Organization

The SHP is a preferred provider organization that has arrangements with doctors, hospitals and other providers of care who have agreed to accept the Plan's allowable charges for covered medical services as payment in full and will not *balance bill* you.

Balance Billing

Balance billing occurs when a non-network provider chooses to charge more for his services than the Plan allows. The difference between what the provider actually charges and what the Plan allows is called the balance bill. If you use a Network provider, you will **not** have to pay balance bills.

Unlimited Access

The SHP gives you unlimited access to hospitals, physicians and other health care professionals who, as being part of our networks, have agreed to file the claims for you. The choice is yours. When you need care, you decide which doctor will take care of you. This applies to your medical benefits only. Please refer to the Mental Health and Substance Abuse section beginning on Page 32 for information on how those benefits are handled.

The SHP's provider network is available on the Internet. You can access the list by using BlueCross Blue Shield's My Insurance Manager. My Insurance Manager can be found on the EIP Web site (www.eip.sc.gov). Simply click on the "Insurance Manager" button, then click the "My Insurance Manager" box. Not only will you be able to search the most current list of participating providers, but you will also be able to:

- ❖ View claims status and Explanation of Benefits (EOB).
- ❖ Check eligibility and read benefits and coverage information.
- ❖ Verify authorization status for inpatient and outpatient visits.
- ❖ Check deductible and out-of-pocket status.
- ❖ Send a secure e-mail question using Ask Customer Service directly to your customer service area.
- ❖ Request a new ID card.

You can also request a hard copy of the provider directory from your benefits office or, if you are a retiree, survivor or COBRA participant, from EIP.

Physician Network

If you need to see a medical doctor, you may benefit from using the SHP Physician Network. The SHP Physician Network is an open network in which all eligible doctors in the state were invited to participate. Since network physicians have agreed to accept the Plan's allowable charges for covered medical services, you will pay only your annual deductible, your coinsurance and any non-covered charges.

Hospital Network

The hospital network applies to all inpatient and outpatient hospital services. All general hospitals in South Carolina participate in the SHP hospital network.

BlueCard Program

You have access to doctors and hospitals almost everywhere, with the BlueCard Program, administered by BlueCross and BlueShield of South Carolina. This program, which applies to your medical benefits, gives you access to BlueCross BlueShield provider networks throughout the United States and around the world through BlueCard Worldwide. Please refer to the Mental Health and Substance Abuse section beginning on Page 32 for information on how those benefits are handled.

With the BlueCard you still have the freedom to choose the doctors and hospitals that best suit you and your family. Follow these five easy steps for health coverage when you are away from home within the United States:

1. Always carry your current SHP identification (ID) card.
2. In an emergency, go directly to the nearest hospital.
3. To find the names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard Access at 800-810-BLUE.
4. Call Medi-Call for pre-certification or prior authorization, if necessary (the toll-free number is listed on your SHP ID card).
5. When you arrive at the participating doctor's office or hospital, simply show your SHP ID card. As a BlueCard program member, the doctor will recognize the logo, which will ensure that you will get the highest level of benefits with no balance billing.

After you receive care, you should not have to complete any claim forms. Nor should you have to pay up front for medical services other than the usual out-of-pocket expenses (deductibles, copayment, coinsurance and non-covered services). You will be mailed a complete explanation of benefits.

When outside the United States, follow the same simple process as in the United States, with the following exceptions:

- ❖ In most cases, you should not need to pay up front for inpatient care at BlueCard Worldwide hospitals. You are responsible for the usual out-of-pocket expenses (deductibles, copayment, coinsurance and non-covered services). The hospital should submit your claim.
- ❖ You pay the doctor or hospital for inpatient care at non-BlueCard world-wide hospitals, outpatient hospital care and other medical services. Then, complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available from your benefits administrator or on-line at www.BCBS.com (benefits are not paid if you use a provider that does not participate in the Mental Health and Substance Abuse provider network).

When outside the United States you can call 800-810-BLUE or collect at 804-673-1177, 24 hours a day, seven days a week, for information on doctors, hospitals and other health care professionals or to receive medical assistance services around the world. A medical assistance coordinator, in conjunction with a medical professional, will make an appointment with a doctor or arrange hospitalization, if necessary.

Remember that the Medicare Supplemental Plan adheres to Medicare-approved charges. Since Medicare does not provide worldwide coverage, BlueCard Worldwide coverage would not apply to the Medicare Supplemental plan subscribers.

Ambulatory Surgical Centers

Ambulatory Surgical Centers are freestanding facilities that provide some of the same services obtained in the outpatient department of a hospital. We have established a network of these facilities that operates the same way as the Hospital Network.

Transplant Contracting

SHP transplant contracting arrangements include the Blue Cross and Blue Shield Association (BCBSA) national transplant network, Blue Quality Centers for Transplants (BQCT). The BQCT consists of a national network of transplant centers. All of the centers in the BQCT network meet specific participation criteria that consider not only provider qualifications and program process, but patient outcomes as well.

As part of this network, those covered by the SHP will have access to the leading transplant facilities in the nation, in addition to the savings the network will bring to the Plan. Contracts are still in effect with several local providers for transplant services so that individuals insured by the Plan may continue to use those facilities. If you receive transplant services at one of these network facilities, you will not have to worry about balance billing. You will be responsible only for your applicable deductible, coinsurance and any charges not covered by the Plan. In addition, these facilities will file all claims for you.

All transplant services must be approved by Medi-Call (see Page 17). You must call Medi-Call even before you or your covered family members are evaluated for a transplant.

Transplant services at nonparticipating facilities will be covered by the Plan. The SHP will pay only the SHP allowed charges for transplants performed at non-network facilities. If you do **not** receive your transplant services at a network facility, you may end up paying substantially more money out of your pocket. In addition to your deductible and coinsurance, subscribers using non-network facilities will be responsible for any amount over these allowable charges and will be subject to a 20 percent out-of-network differential (see next section). Costs for transplant care can vary by hundreds of thousands of dollars, and if you choose care outside of the network, you cannot be assured that your costs will not exceed those allowed by the Plan. Call Medi-Call for more information on this limited non-network benefit. Remember, all transplant services must be approved by Medi-Call.

If you or your covered family member were approved by Medi-Call and on a waiting list for transplant care at a non-network facility before July 1, 1994, you will not have your benefits limited.

Out-of-Network Benefits

Out-of-network Differential

With the SHP, you have the freedom to choose which provider you wish to use. However, if you choose a provider that does not participate in a SHP network or the BlueCard program, you will pay 20 percent more in coinsurance. This means you will be responsible for 45 percent of the coinsurance if you have the Economy plan or 40 percent if you are covered under the Standard plan. Non-network providers are also free to charge you any price for their services so you may pay more. Here's how the out-of-network differential works if you are covered under the SHP Standard plan:

- ❖ If you have not met your deductible and choose to go to a non-network provider, you may be responsible for 100 percent of the covered charges, any applicable per-occurrence or per visit deductibles (which would not apply toward meeting your deductible), as well as risk being balance billed by the provider for charges that were not covered. Only the covered amount would apply to the annual deductible.
- ❖ If you have met your deductible and choose to see a non-network provider, you will be responsible for 40 percent, instead of the usual 20 percent, of the covered charges, any applicable per-occurrence or per visit deductibles and risk being balance billed.

Although benefits are allowed for medical services received from nonparticipating hospitals and physicians, prescription drug and mental health and substance abuse benefits are NOT payable if you use a nonparticipating provider.

Medi-Call

What Is It? Medi-Call is the SHP's utilization review program. Medi-Call makes sure you and your covered family members receive appropriate medical care in the most beneficial, cost-effective manner.

When Must I Call? **Participation in Medi-Call is mandatory.** You must call 803-699-3337 in Columbia or 800-925-9724 in South Carolina, nationwide and Canada when:

- ❖ You need inpatient care in a hospital¹;
- ❖ You need outpatient surgery for septoplasty, hysterectomy or sclerotherapy;
- ❖ You need a MRA, MRI or CT Scan;
- ❖ You will be receiving chemotherapy or radiation therapy;
- ❖ Your precertified outpatient services result in a hospital admission (you must call again);
- ❖ You need a second opinion;
- ❖ You are admitted to a hospital in an emergency situation (your admission must be reported within 48 hours or the next working day)¹;
- ❖ You are diagnosed as being pregnant (you must call within the first three months of your pregnancy);
- ❖ You have an emergency admission during pregnancy¹;
- ❖ You deliver your baby²;
- ❖ Your newborn has complications at birth;
- ❖ You are admitted to a skilled nursing facility, utilize home health care, hospice care or an alternative treatment program or need durable medical equipment;
- ❖ You or your covered family members decide to undergo any In Vitro Fertilization (IVF) procedure;
- ❖ You or your covered family member need to be evaluated for a transplant;
- ❖ You need inpatient rehabilitative services and related outpatient physical, speech and occupational therapies;
- ❖ Any procedure that may potentially be considered cosmetic in nature must be received in writing by Medi-Call seven days prior to surgery (i.e., blepharoplasty, reduction mammoplasty, TMJ or other jaw surgery).

¹For mental health or substance abuse services, you must call APS Healthcare at 800-221-8699 for precertification prior to admission, or within 24 hours of an emergency admission.

²Contacting Medi-Call for the delivery of your baby does not add that baby to your health insurance. You must add your child by completing and filing an NOE, within 31 days of birth for benefits to be payable.

Medi-Call approval does not guarantee payment of benefits. Claim payments are still subject to the rules of the Plan.

Are There Penalties for Not Calling? Yes. If you do not call Medi-Call in the required situations, you will be required to pay a \$200 penalty for each hospital or skilled nursing facility admission. In addition, the \$2,000/\$4,000 coinsurance maximum will not apply. In other words, you will continue to pay your coinsurance no matter how high your charges get. If you do not call APS Healthcare for approval for each mental health or substance abuse admission, services will not be covered.

State Health Plan Benefits

The Economy plan and the Standard plan pay benefits for medically necessary treatments of illnesses or injuries. This is a brief summary of the Plan's general benefits.

The Plan document contains a complete description of the benefits. Its terms and conditions govern all health benefits offered by the state. Contact your benefits administrator or EIP for more information. Some services and treatments require precertification by Medi-Call or APS Healthcare. Be sure to read the Medi-Call and the Mental Health and Substance Abuse sections of this booklet for details.

Ambulance	Ambulance service to or from the nearest hospital is covered when medically necessary and ordered by a physician or in an emergency medical situation.
Doctor Visits	Charges for treatments or consultations for an injury or illness are covered as long as they are medically necessary. The per visit deductible is \$10 which does not apply to your annual deductible or out-of-pocket maximum. This deductible is waived for routine pap smears, routine mammograms and well child care visits. For mental health and substance abuse services to be covered, you must use a participating provider and all mental health and substance abuse services must be pre-authorized.
Extended Role Nurse	Expenses for services received from a licensed, independent extended role nurse are covered, even if these services are not performed under the direction of a doctor. An extended role nurse is a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist or a clinical nurse specialist. All services received must be within the scope of their license.
Infertility	<p>The Plan will pay for diagnosis and treatment of infertility under the following terms and conditions: maximum lifetime benefits are \$15,000 per person; a maximum of three cycles of gamete or zygote intrafallopian transfer (GIFT or ZIFT), or In Vitro Fertilization (IVF), are allowed; benefits are payable at 70 percent of allowable charges. Your share of the expenses does not count toward your coinsurance maximum. All IVF procedures must be approved by Medi-Call.</p> <p>The Plan will not provide infertility benefits to subscribers who have had a prior tubal ligation. Prescription drugs for treatment of infertility are subject to a 30 percent coinsurance payment, which does not apply to the \$2,500 annual per person out-of-pocket maximum. The 70 percent plan payment for prescription drugs for infertility treatments does apply to the Plan's \$15,000 maximum lifetime benefit for infertility treatments. Call Medco Health Solutions' Member Services at 800-711-3450 for more information.</p>
Inpatient Hospital Services	Inpatient hospital care, including room and board, is covered. In addition to your normal visits by your physician while you are in the hospital, you are covered for one consultation per consulting physician for each inpatient hospital stay.

Outpatient Services	<p>Outpatient laboratory, X-ray, emergency room, radiation therapy, pathology services, outpatient surgery, diagnostic tests and medical supplies are covered (if the diagnosis is psychiatric, only services provided at APS network facilities are covered). The deductible for each emergency room visit is \$125. This deductible is waived if you are admitted to the hospital. The deductible for each outpatient hospital service is \$75. This deductible is waived for dialysis, routine mammograms, routine pap smears, clinic visits (an office visit at an outpatient facility; clinic visits are not covered if filed with a psychiatric diagnosis), emergency room, oncology, electro-convulsive therapy, psychiatric medication management and physical therapy visit.</p>
Pregnancy and Pediatric Care	<p>Pregnancy benefits are provided to a female employee and the dependent wife of a male employee. Dependent children do not have maternity benefits. Maternity benefits include necessary prenatal and postpartum care, including childbirth (hospital stay of 48 hours for a normal vaginal delivery or 96 hours for a caesarian section), miscarriage and complications related to pregnancy. If you are pregnant you must enroll in the Maternity Management Program. See Page 23 for more information.</p>
Reconstructive Surgery After Mastectomy	<p>If you have a mastectomy and elect to have breast reconstruction in connection with the mastectomy, the Plan will cover:</p> <ul style="list-style-type: none"> ❖ Reconstruction of the breast on which the mastectomy has been performed; ❖ Surgery and reconstruction of the other breast to produce a symmetrical appearance; and ❖ Prostheses and physical complications of all stages of mastectomy, including lymphedemas.
	<p>Remember that these services apply only in post-mastectomy cases, and that all services must be approved by Medi-Call.</p>
Rehabilitation	<p>The Plan does provide some rehabilitation benefits. These limited benefits are subject to the terms and conditions of the Plan, including:</p> <ul style="list-style-type: none"> ❖ Precertification is required for any inpatient admission and outpatient rehabilitation therapy that occurs subsequent to an inpatient admission for rehabilitation therapy; ❖ The requirement that there is reasonable expectation that sufficient function can be restored for the patient to live outside the hospital settings; ❖ That significant improvement continues to be shown. <p>The Plan does not pay for:</p> <ul style="list-style-type: none"> ❖ Long term rehabilitation after the acute phase of treatment for injury or illness; ❖ Vocational rehabilitation; ❖ Pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant); ❖ Behavior therapy, including speech therapy associated with behavior; ❖ Cognitive retraining; ❖ Community re-entry programs.

**Second
Opinion**

If Medi-Call advises you to seek a second opinion before a medical procedure, the Plan will pay 100 percent of the cost for that opinion. These procedures include surgery as well as treatment (including hospitalization). If APS Healthcare advises you to seek a second opinion before receiving treatment for mental health or substance abuse services, the Plan will pay 100 percent of the cost for that opinion.

Surgery

Physician charges for medically necessary inpatient surgery, outpatient surgery and use of surgical facilities are covered.

**Other
Covered
Expenses**

The following expenses are covered if they are determined to be medically necessary:

- ❖ certain organ transplants;
- ❖ blood and blood plasma;
- ❖ nursing services;
- ❖ durable medical equipment;
- ❖ prosthetic appliances;
- ❖ oxygen and necessary rental equipment;
- ❖ orthopedic braces, crutches, lifts attached to braces and orthopedic shoes;
- ❖ dental treatments or surgery to repair damage from an accident, for up to one year from the date of the accident;
- ❖ dental surgery for bony, impacted teeth.

Alternative Treatment

The Plan will pay benefits for extended care as an alternative to hospital care only if it is approved by Medi-Call.

Skilled Nursing Facility

The Plan will pay limited benefits for room and board in a skilled nursing facility for up to 60 days or \$6,000 based on a per diem rate, whichever is less. Physician visits are limited to one per day.

Hospice Care

The Plan will pay benefits for care you receive from a hospice agency for patients who are terminally ill. The maximum benefit is \$6,000 per covered person, including a bereavement counseling maximum of \$200.

Alternative Treatment Plans

An alternative treatment plan is an individual treatment program to permit treatment in a cost-effective and less intensive manner than ordinarily required. It requires the approval of the treating physician, BlueCross BlueShield of South Carolina, Medi-Call and the patient. Services and supplies that are medically necessary because of the approved alternative treatment plan will be covered.

Home Health Care

The Plan covers home health care performed by a private or public agency. You cannot receive home health care and hospital or skilled nursing care benefits at the same time. Benefits are limited to \$5,000 or 100 visits per year, whichever is less.

Natural Blue

“Natural Blue” is a discount program available to SHP subscribers. A part of BlueCross and BlueShield of South Carolina, “Natural Blue” offers holistic health care choices and information. The program has a network of credentialed acupuncturists, massage therapists and fitness clubs that may be used at reduced fees, often as much as 25 percent. “Natural Blue” also offers discounts on laser vision correction and discounted health products such as vitamins, herbal supplements, books and tapes. For more information on “Natural Blue,” log on to the Web site at www.healthyroads.com.

Preventive Benefits

The SHP has benefits and programs that can help make staying healthy easier for you and your family and help guide you through the health care process when you become ill.

These preventive care and disease management benefits provide you with resources to help you stay healthy, feel better and enjoy a better quality of life, as well as provide a cost savings. By helping to prevent potentially expensive health problems and hospital admissions, these SHP benefits help control medical claims costs, saving you and the Plan money.

Prevention Partners

Prevention Partners is a benefit of the SHP that is designed to help you and your family lead healthier lifestyles.

Mission Statement

Prevention Partners educates volunteer coordinators and benefits administrators at worksites throughout the state. The mission of Prevention Partners is to provide activities, programs and services in the following areas:

- ❖ Disease prevention;
- ❖ Early detection of disease;
- ❖ Demand management;
- ❖ Health promotion.

Programs

As a way to encourage health promotion, disease prevention and early detection of disease, Prevention Partners conducts the following programs:

- ❖ Spring Wellness Walk;
- ❖ Annual Health at Work Conference;
- ❖ Chronic Disease Management workshops in asthma, diabetes, hypertension and healthy heart;
- ❖ Worksite Program Consultation;
- ❖ Volunteer Worksite Prevention Partners Coordinator Network;
- ❖ Yearly regional meetings.

Preventive Worksite Screening

This comprehensive health screening, coordinated by Prevention Partners, measures lifestyle risk behaviors, cholesterol levels, blood pressure, triglyceride levels, weight, written health risk appraisal, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia. This benefit is available once per calendar year to subscribers for whom the SHP is the primary payer for a \$15 copayment.

Contact

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 803-737-3820 in Columbia or 888-260-9430 statewide. You can also go to the Web site at www.eip.sc.gov.

Early Detection Benefits

Mammography Testing Program

Routine, four-view mammograms are covered at 100 percent as long as you use a participating facility and meet eligibility requirements. You do not need a doctor's referral for a routine mammogram under the Plan.

- ❖ If you are age 35 through 39, one baseline mammogram will be covered during those years.
- ❖ If you are age 40 through 49, one routine mammogram every other year will be covered.
- ❖ If you are age 50 through 74, one routine mammogram a year will be covered.

Charges for routine mammograms performed at nonparticipating facilities are not covered, with the exception of procedures performed outside of South Carolina.

For women covered through the retiree group and entitled to Medicare, Medicare pays for one routine mammogram every year for Medicare-entitled women age 40 and older. The SHP is primary for women covered through the active group regardless of Medicare entitlement.

Pap Test Program

The Plan will pay a benefit each year for a Pap test if you are a covered female age 18 through 65. You can receive this benefit whether or not the Pap test is for routine or diagnostic purposes. The benefit does not include the doctor's visit.

Maternity Management Program

If you are a mother-to-be, you **must** take enroll in the Maternity Management Program administered by Medi-Call. Prenatal care is a good way to ensure your health and your baby's health. You must call Medi-Call within the first trimester (three months) of your pregnancy to precertify your pregnancy. If you do not call Medi-Call within the first trimester of your pregnancy or you refuse to participate in the Maternity Management Program, you will pay a \$200 penalty for each maternity-related hospital or skilled nursing facility admission. This penalty will be in addition to the existing Medi-Call precertification penalty and the \$2,000 coinsurance maximum will not apply.

You are automatically enrolled in the program when you call Medi-Call to precertify your pregnancy. As a participant in the program, you will receive a letter from Medi-Call welcoming you to the program and a packet of important information you will want and need to refer to during your pregnancy.

A case management nurse will complete a Maternity Health Assessment form when you enroll. This form is used to identify potential high risk factors during your first trimester. If high risk factors are identified through this process, you will be scheduled for periodic follow-up calls. If no risks are identified, you should call with any changes in your status. Otherwise, you will be sent a reminder card with benefit information during your third trimester.

Plus, you can call Medi-Call anytime you have questions. A maternity case management nurse will be there to help you throughout your pregnancy. **Remember, there are penalties for not participating in this program. See Medi-Call on Page 17 for more details.**

Well Child Care Benefit

What Is Well Child Care?	The SHP will provide coverage for routine checkups and immunizations for children through age 12. Well Child Care benefits are designed to promote good health and aid in the early detection and prevention of illness among our children.
Who Is Eligible?	Covered dependent children from birth through age 12 are eligible for the Well Child Care benefit.
How Does It Work?	<p>This benefit covers both regular doctor visits and timely immunizations. When services are received from a doctor in the SHP Physician Network, benefits will be paid at 100 percent without any deductible or coinsurance. Benefits will not be paid for services obtained from non-network providers. Some services may not be considered as part of the well child visit. For example, if during a well child visit a fever and sore throat were discovered, the lab work performed to verify the diagnosis would not be part of the routine visit. These charges would be subject to deductible and coinsurance as with any other medical expense.</p>
Checkups	<p>The Plan has developed a schedule of regular checkups for which the Plan pays 100 percent when obtained from a Network doctor:</p> <ul style="list-style-type: none">❖ less than one year old—five visits;❖ 1 year—three visits;❖ 2 through 5 years—one visit per year;❖ 6 through 8 years—one visit during three year period;❖ 9 through 12 years—one visit during four year period.
Immunizations	When you use a Network doctor, the Plan pays 100 percent of the cost for your children's immunizations at the appropriate ages. The recommended schedule for immunizations is listed on the following page.

Disease	Recommended Immunization Schedule
Hepatitis B	birth-2 months 1-4 months 6-18 months 11-12 years if not had before
Polio	2 months 4 months 6-18 months 4-6 years
Diphtheria-Tetanus-Pertussis (DTaP)	2 months 4 months 6 months 15-18 months 4-6 years 11-12 years if none in last five years (Td)
Haemophilus (Hib)	2 months 4 months 6 months 12-15 months
Pneumococcal Conjugate(PCV7)	2 months 4 months 6 months 12-15 months
Measles-Mumps-Rubella(MMR)	12-15 months four-six years 11-12 years if not had second dose before
Chickenpox	12-18 months 11-12 years if not had disease or vaccine before

If your children have not been immunized within the recommended time frames, please contact your pediatrician or call Medi-Call for instructions on how to get your children properly immunized.

Managing For Tomorrow®

If you have a chronic condition such as diabetes, heart disease or asthma, you know that taking care of yourself can be challenging. It's a 24-hours-a-day, seven-days-a-week effort. Being a good self-manager starts with understanding your condition and your doctor's plan of care.

There's a program that can help. Managing for Tomorrow® is available to active employees, non-Medicare retirees, spouses and dependents covered by the SHP. You may receive a letter or phone call about this unique health management program sponsored by BlueCross BlueShield of South Carolina in cooperation with the SHP Prevention Partners.

The program is designed to help you learn more about your condition and ways to improve your health. It is voluntary and offered at no cost. You won't be asked to purchase anything, your benefits will not be affected and your premiums or copayments will not increase when you participate in Managing for Tomorrow®.

The program starts with a confidential survey. The survey helps determine what health education materials are right for you. The invitation includes a special Personal Identification Number (PIN). This PIN will allow you to complete the survey either by calling an automated phone line or by logging on to a secure Web site. Paper surveys are also available.

Everyone who receives this invitation is encouraged to take part in the Managing for Tomorrow® program. If you think you qualify but have not received an invitation, call the BlueCross Disease Management department at 800-925-9724.

Complex Care Management Program

Facing a serious illness or injury often can be overwhelming, confusing and frustrating. You may not know where to find support or information to help you cope with your illness, and you may not know what treatment options are available.

But now there's a program that you can turn to for help. Available to active employees, spouses and dependents covered by the SHP, this Complex Care Management program lets you make informed decisions about your healthcare when you are seriously ill or injured.

Offered by BlueCross BlueShield of South Carolina and Franklin Health, Inc., the program provides you information and support through a local care coordinator who is a registered nurse. This coordinator acts as an advocate for you and your family, by helping you identify treatment options, locating special supplies and equipment recommended by your doctor, coordinating care with your doctor and the SHP, and researching the availability of special transportation and lodging for out-of-town treatments.

Participation in the program is voluntary and is offered free of charge. You can leave the program at any time, for any reason. Your benefits will not be affected by your participation in the program.

Here's how the program works: BlueCross BlueShield will refer you to Franklin Health if the program is of benefit to you. You'll receive a letter explaining the program, and a Franklin Health representative will contact you. A care coordinator in your area will visit you to discuss ways he can help you and will ask permission to contact your doctor to offer assistance.

The Franklin Health team, comprised of specially trained nurses and doctors, will review your medical information and treatment plan (please note that your medical history and information will always be kept confidential among your caregivers and the Franklin Health team).

Your local care coordinator will be your main program contact. You and your doctor, however, will always have the final decision about your treatment options.

Everyone who is referred to Franklin Health is encouraged to take part in the Complex Care Management program. By working closely with your doctor and using the resources available in your community, the program can help you through a difficult time in your life. If you would like more information on this Complex Care Management program, call 800-868-2500, ext. 42648.

Prescription Drug Program

	Economy Plan ¹	Standard Plan ¹
Prescription Drug¹ Deductible Per Year	No Annual Deductible	No Annual Deductible
Copayments for up to a 31-day supply (retail)	\$10 Generics \$25 Preferred Brand Name \$40 Non-preferred Brand Name	\$10 Generics \$25 Preferred Brand Name \$40 Non-preferred Brand Name
Mail order copayments for up to a 90-day supply	\$23 Generics \$56 Preferred Brand Name \$90 Non-preferred Brand Name	\$23 Generics \$56 Preferred Brand Name \$90 Non-preferred Brand Name
Copayment Maximum	\$2,500 Per Person (applies to prescription drugs only)	\$2,500 Per Person (applies to prescription drugs only)

¹Benefits are payable for prescriptions filled at participating pharmacies only. A “pay-the-difference” policy also applies. This means if a generic drug is available and you purchase a brand name medication instead, the benefit will be limited to the benefit for the generic drug and you will be responsible for the price difference. This difference does not apply to the annual copayment maximum.

State Health Plan Prescription Drug Program

The Prescription Drug Program, administered by Medco Health Solutions, Inc., is both easy and convenient to use. With this program, you simply show your SHP identification (ID) card when you purchase your prescriptions from a participating pharmacy and pay a copayment of either \$10 for generic drugs, \$25 for preferred brand name or \$40 for non-preferred brand name medications for up to a 31-day supply. If the price of your prescription is less than the copayment amount, you pay the lesser amount. **Prescription drug benefits are payable without an annual deductible.** There are no claims to file. The Prescription Drug Program’s benefits are the same for each SHP: Economy, Standard and Medicare Supplemental.

Prescription drugs, including insulin, are covered subject to Plan exclusions and limitations, provided you use a participating pharmacy. Drugs in FDA Phase I, II or III testing are not covered. Prescription medications associated with infertility treatments have a different coinsurance rate. Please refer to Page 18 for more information.

Under this program, prescription drug costs are separate from your medical coverage. This means that drug expenses do not count toward your medical annual deductible, coinsurance maximum or your lifetime maximum benefit for other health benefits.

The prescription drug plan has a separate annual copayment maximum of \$2,500 per person. This means that once you have spent \$2,500 in prescription drug copayments, the Plan will cover your allowable prescription drug expenses at no cost to you for the remainder of the plan year.

The SHP Prescription Drug Program is a three tiered program. This means your prescription choices are divided into three categories: generic, preferred brand name and non-preferred brand name. Each category has its own copay amount.

Generic Drugs	Generic medications may differ in color, size, or shape, but the FDA requires that the active ingredients have the same strength, purity and quality as the brand-name alternatives. Prescriptions filled with generic drugs often have lower copayments. Therefore, you can get the same health benefits at a lower cost.
“Pay-the-Difference”	The prescription drug plan has a “pay-the-difference” policy. This means that if a generic drug is available, and you purchase the brand name medication instead (or your doctor prescribes the brand name drug), the benefit will be limited to the cost of the generic medication and you will be responsible for the price difference. “Pay-the-difference” amounts do not apply toward the copayment maximum.
Preferred Brand Name Drugs	These are medications that Medco Health’s Pharmacy and Therapeutics Committee has determined safe, effective and available at a lower cost. A list of preferred brand medications is available online at www.medcohealth.com .
Non-Preferred Brand Name Drugs	These are medications that do not appear on the Preferred Brand Name list and that carry a higher copayment. All medications that appear on the non-preferred brand list have an effective alternate option either as a generic or preferred brand name drug.
Diabetic Supplies	Insulin is allowed under the Prescription Drug Program or under the medical plan but not both. Since most insulin is brand name, it will require a \$25 copayment for each supply of up to 31-days. Diabetic supplies, including syringes, lancets and test strips will be covered at participating pharmacies for a \$10 copayment for each item, for each supply of up to 31 days. Durable medical equipment, which includes insulin and diabetic supplies, continues to be payable under the SHP. Claims for durable medical equipment should be filed with BlueCross BlueShield of South Carolina.

Medicare covers some diabetic supplies for people with Medicare with diabetes (insulin users and non-insulin users). These include limited quantities of:

- ❖ blood glucose test strips (**Important Note:** Effective April 1, 2002, all Medicare enrolled pharmacies and suppliers must submit claims for glucose monitor test strips. You cannot send in the claim for glucose test strips yourself.),
- ❖ blood glucose meter,
- ❖ lancet devices and lancets, and
- ❖ glucose control solutions for checking the accuracy of test strips monitors.

If Medicare is primary for you, you should file these claims with Medicare first. For more information on how Medicare covers diabetic supplies, go to Medicare's Web site at www.medicare.gov.

Contraceptives Routine contraceptive prescriptions, including birth control pills and injectibles (Depo-Provera and Lunelle), for employees and covered spouses that are filled at a participating pharmacy are covered under the Prescription Drug Program subject to the same terms as other prescription drugs. Birth control implants and injectibles that are given in a doctor's office will be paid as a medical claim.

Prior Authorization Some medications will be covered by the Plan only if they are prescribed for certain uses. For this reason, some drugs must receive prior authorization before they are covered under the Plan. If the prescribed medication must be pre-authorized, you or your pharmacist may initiate the review process by contacting Medco Health Solutions at 800-711-3450.

Retail Pharmacy You must use a participating pharmacy and you must show your SHP ID card when purchasing your medications. The SHP participates in the Select Rx Network, Medco Health's pharmacy network. Most major pharmacy chains and independent pharmacies participate in this network. A list of participating pharmacies is available online at www.medcohealth.com.

Home Delivery The SHP Prescription Drug Program also offers a mail order service for prescription drugs. Generic medication copayments are \$23, preferred brand name medication copayments are \$56 and non-preferred brand name medication copayments are \$90 for up to a 90-day supply. This is how the Home Delivery mail order service works:

- ❖ First, ask your physician to write your prescription for a 90-day supply with refills.
- ❖ Complete a mail order prescription form and mail it to Medco Health Solutions (forms are available on Medco Health's Web site: www.medcohealth.com).
- ❖ Your order will be processed and sent to your home, typically within 10-14 business days.

Once the initial prescription has been entered and filled, you may order refills online or by phone using Medco Health's toll-free number: 800-711-3450. Considering the cost for the quantity (\$23 for generic, \$56 for preferred brand and \$90 for non-preferred brand, for up to a 90-day supply), taking advantage of this service may **save** you money. It is an ideal option for anyone with a recurring prescription (such as birth control medication) or chronic conditions such as asthma, high cholesterol or high blood pressure.

For Home Delivery mail order, be sure to have your doctor write a prescription for a **90-day supply**. Prescriptions received at Home Delivery written for a 30-day supply with refills will be filled for a 30-day supply, but you will be charged the full, 90-day Home Delivery copay.

How to File a Prescription Drug Claim

If you fail to show your SHP ID card, or if you incur prescription drug expenses while traveling out of the United States, you will have to pay full retail price for your medication, then file a claim with Medco Health Solutions for reimbursement. Reimbursement will be limited to the Plan's allowable charge less the copayment. You must file your claim to Medco Health Solutions within one year of the date of service.

Remember that benefits are NOT payable if you use a non-participating pharmacy. However, if you incur prescription drug expenses at a nonparticipating pharmacy while traveling out of the United States, you will be able to file a claim with Medco Health Solutions for reimbursement of your expenses, which will be limited to the Plan's allowable charge less the copayment.

To file a claim for prescription drug expenses incurred at a participating pharmacy or incurred outside the United States, you need to call Medco Health Solutions' Member Services at 800-711-3450.

What If My Claim is Denied?

If Medco Health Solutions denies all or part of your claim, they will let you know soon after the decision is made and the reason why. If you have questions about the decision, check the information in this guide or call Medco Health Solutions for an explanation.

If you are unsure whether the decision was fair, you can ask Medco Health Solutions to re-examine the denial of your claim. The request for review should be made in writing to Medco Health Solutions and should be done within six months after notice of the decision. If you wait too long, the decision will be considered final. If you are still dissatisfied after Medco Health Solutions has reviewed its decision, you may request that EIP review the matter by making a written request to EIP within 90 days of notice of Medco Health's denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

Mental Health and Substance Abuse Benefits

APS Healthcare, Inc., is the SHP administrator for the Mental Health and Substance Abuse benefit. Claims for mental health and substance abuse are subject to the same deductibles, coinsurance and out-of-pocket maximums as medical claims. There are no caps on the number of provider visits allowed, and there is not a separate annual and lifetime maximum for substance abuse benefits. Here is how the SHP mental health and substance abuse program works:

- ❖ When you need care, simply call toll-free 800-221-8699 to receive preauthorization and be directed to a national network of providers. The provider network is an open network. This means that any eligible provider can participate in the network. **If you choose to use a nonparticipating provider, no benefits will be paid.**
- ❖ In order to review the network of participating providers, simply log on to www.apshealthcare.com. Once you are on APS' Web site, click on "South Carolina State Employees." Next click on "Connect to Online Provider Locator." Then you will need to enter the SHP's access code, which is "statesc" (all lower case). Finally click on "Accept." You will then be able to search the directory by entering a provider's name or by entering a geographical area. You may also nominate providers for inclusion in the network on this Web site. If you would like to view or download the network directory, click on "SC Provider/Facilities Directories" and enter "statesc."
- ❖ There is no limit to the amount of care you may receive as long as it is authorized as being medically necessary. **All services (inpatient hospital admissions, etc.) must be precertified by APS Healthcare to be considered covered services.**
- ❖ There are no claims to file. Your participating provider will be directly responsible for submitting claims for these services.
- ❖ Your participating Mental Health and Substance Abuse provider will be required to conduct periodic medical necessity reviews (similar to Medi-Call).
- ❖ For claims or customer service assistance for mental health and/or substance abuse care, call APS Healthcare at 800-221-8699.

Mental Health and Substance Abuse Benefits Claims

There are no claims to file when you receive mental health or substance abuse services from a participating provider. These providers are directly responsible for submitting claims to APS Healthcare for services rendered.

Remember that no benefits are paid if you receive care from a nonparticipating provider.

**What If I
Need Help?**

APS Healthcare has a special unit totally dedicated to processing SHP mental health and substance abuse claims, and representatives are available to help you with any questions about your claims. You can call APS Healthcare at 800-221-8699 or write to the following address:

APS Healthcare, Inc.
Claims, State of SC
P.O. Box 1307
Rockville, MD 20849

**What If My
Claim or
Request For
Precertification
Is Denied?**

If APS Healthcare denies all or part of your claim or denies a request for precertification, you will be notified of the denial and reason soon after the decision is made. If you have questions about the decision, check the information in this booklet or call APS Healthcare for an explanation.

If you are unsure whether the decision was fair you can ask that APS Healthcare re-examine the denial of your claim or re-examine the precertification decision. The request for review should be made in writing to APS Healthcare and should be done within six months after notice of the decision. If you wait too long, the decision will be considered final.

If you are still dissatisfied after APS Healthcare has reviewed its decision, you may request that EIP review the matter by making a written request to EIP within 90 days of notice of APS' denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

State Health Plan Exclusions

There are some medical expenses the Plan does not cover. They include services or supplies that are not medically necessary and routine procedures not related to the treatment of injury or illness. *The Plan of Benefits* document (available in your benefits office) lists all of the exclusions. Some expenses that are not covered are:

- ❖ Services related to a pre-existing condition in the first 12 months (or 18 months for late entrants) of coverage (may be reduced by any creditable coverage you bring to the Plan);
- ❖ Routine physical exams, checkups (except well child care and worksite preventive screenings according to guidelines), services, surgery (including cosmetic surgery) or supplies that are not medically necessary;
- ❖ Eyeglasses, contact lenses (unless medically necessary after cataract surgery and for the treatment of keratoconus) and routine eye examinations;
- ❖ Refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea;
- ❖ Hearing aids and examinations for fitting them;
- ❖ Dental services, except for removing impacted teeth or treatment within one year of a condition resulting from an accident;
- ❖ TMJ splints, braces, guards, etc. (medically necessary surgery for TMJ is covered);
- ❖ Custodial care, including sitters and companions;
- ❖ Over-the-counter contraceptive devices;
- ❖ Services connected with a vasectomy or tubal ligation performed within one year of enrollment; surgery to reverse a vasectomy or tubal ligation;
- ❖ Services for infertility treatment for subscribers who have had a prior tubal ligation;
- ❖ Assisted reproductive technologies, except as noted on Page 18 of this section;
- ❖ Experimental surgery or services;
- ❖ Diet treatments, including, but not limited to the following: gastric bypass or stapling, intestinal bypass and any related procedures, except

gastric bypass and gastric stapling when medically necessary for the treatment of morbid obesity. Benefits for the surgical revision, reversal or the treatment for the consequences of bariatric surgery such as abdominoplasty are limited to procedures that are medically necessary to treat intractable functional problems that are refractory to medical or non-surgical treatment;

- ❖ Equipment that has a non-therapeutic use (such as humidifiers, air conditioners, whirlpools, wigs, artificial hair replacement, vacuum cleaners, home and vehicle modifications, fitness supplies, speech augmentation or communication devices, including computers, etc.);
- ❖ Supplies used for participation in athletics that are not necessary for activities of daily living;
- ❖ Physician charges for medicine, drugs, appliances, supplies, blood and blood derivatives unless approved by the third party claims administrator;
- ❖ Medical care by a doctor on the same day or during the same hospital stay in which you have surgery, unless a medical specialist is needed for a condition the surgeon could not treat;
- ❖ Physician's charges for clinical pathology, defined as services for reading any machine-generated reports or mechanical laboratory tests;
- ❖ Fees for medical records and claims filing;
- ❖ Services performed by the insured or a relative;
- ❖ Acupuncture;
- ❖ Chronic pain management programs;
- ❖ Transcutaneous electrical nerve stimulation, whose primary purpose is the treatment of pain;
- ❖ Psychological tests to determine job, occupational or school placement or for educational purposes; milieu therapy, or to determine learning disability;
- ❖ Services or supplies payable by Workers' Compensation or any other governmental or private program (including Employee Assistance Program services);
- ❖ Charges for treatment of illness or injury or complications caused by acts of war or military service, injuries received by participating in a riot, insurrection, felony or any illegal occupation;
- ❖ Nicotine patches used in smoking cessation programs, as well as prescribed drugs used to alleviate the effects of nicotine withdrawal;

- ❖ Vocational rehabilitation, pulmonary rehabilitation (except in conjunction with a covered and approved lung transplant), behavior therapy, including speech therapy associated with behavior, cognitive retraining, community reentry programs or long term rehabilitation after the acute phase of treatment for the injury or illness;
- ❖ Congenital anomaly is not covered unless the covered person has been continuously covered under the Plan from birth until the time of treatment;
- ❖ Sclerotherapy, including injections of sclerosing solutions for varicose veins of the leg, unless a prior approved ligation or stripping procedure has been performed within three years and documentation establishes that some varicosities remained after the prior procedure;
- ❖ Animals trained to aid the physically challenged; and
- ❖ Abortions, except if pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

How to File a Claim for Medical Services

If you received services from a physician or hospital that participates in a SHP network, you do not have to file. Your doctor or hospital will file for you and receive payment directly from the Plan. You will also receive an Explanation of Benefits from BlueCross BlueShield explaining how your claim was paid.

If you did not use a network physician or hospital, or have a claim for a non-network service, you may have to file the claim yourself. You can get claim forms from your benefits office, EIP, EIP's Web site at www.eip.sc.gov or BlueCross BlueShield. To file a claim you need to:

- ❖ complete the entire front side of the claim form;
- ❖ attach your itemized bills, which must show: the amount charged; the patient's name; the date and place of service; the diagnosis, if applicable; and the provider's federal tax identification number, if available;
- ❖ file claims within 90 days of the date you receive services or as soon as reasonably possible.

You do not have to wait until you have accumulated your annual deductible. Don't wait too long, because BlueCross BlueShield must receive medical claims by the end of the calendar year after the year in which expenses are incurred. Otherwise, claims cannot be paid.

Complete a separate claim form for each individual who has received care. Then, mail the form to BlueCross BlueShield at:

State Group Processing Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605.

If you obtain medical services while outside South Carolina and the United States at a BlueCard doctor or hospital, in most cases, you should not need to pay up front for inpatient care. You are responsible for the usual out-of-pocket expenses (deductible, copayment, coinsurance and non-covered services). The doctor or hospital should submit your claim.

At non-BlueCard doctors and hospitals, you pay the doctor or hospital for inpatient care, outpatient hospital care and other medical services. Then, complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available from your benefits administrator or online at www.eip.sc.gov or www.southcarolinablues.com.

**What If I
Need Help?**

BlueCross BlueShield has developed a special unit totally dedicated to processing SHP medical claims. This unit will do everything possible to help you. You can call BlueCross BlueShield at:

In Columbia 803-736-1576
Nationwide 800-868-2520

If you cannot call, write BlueCross BlueShield at:

State Group Processing Unit
BlueCross BlueShield of South Carolina
P.O. Box 100605
Columbia, SC 29260-0605.

**What If My
Claim or
Request for
Precertification
of Benefits
is Denied?**

If BlueCross BlueShield denies all or part of your claim, or Medi-Call denies a request for precertification, they will let you know soon after the decision is made and the reason why. If you have questions about the decision, check the information in this booklet or call BlueCross BlueShield or Medi-Call for an explanation.

If you are unsure whether the decision was fair you can ask that BlueCross BlueShield re-examine the denial of your claim, or that Medi-Call re-examine the precertification decision. The request for review should be made in writing to BlueCross BlueShield or Medi-Call and should be done within six months after notice of the decision. If you wait too long, the decision will be considered final.

If you are still dissatisfied after BlueCross BlueShield or Medi-Call has reviewed its decision, you may request that EIP review the matter by making a written request to EIP within 90 days of notice of BlueCross BlueShield's or Medi-Call's denial. If the denial is upheld by EIP, you have 30 days to seek review in the circuit court pursuant to S.C. Code Ann. 1-23-380 (Law. Co-op. 1986 & Supp. 2001).

Double Coverage

**Coordination
of Benefits**

A person covered under more than one group health insurance plan can file a claim for reimbursement from both plans.

If you file more than one claim for reimbursement, your plan administrators will coordinate benefits so you get the maximum amount allowed. That amount will never exceed 100 percent of your covered medical or prescription expenses.

If a husband and wife have two different group insurance plans and both cover their children, the parent whose birthday comes first in the calendar year must file a claim under his or her insurance first.

If you and/or your covered dependents are eligible for Medicare and are covered under the active employee group, the SHP is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

If the SHP is the secondary payer for the health claim, you must file the Explanation of Benefits from your primary plan directly to BlueCross BlueShield of South Carolina. Prescription drug claims for expenses incurred with a participating pharmacy or outside the United States should be filed with Medco Health Solutions. Mental health and substance abuse claims should be filed with APS Healthcare, Inc.

Subrogation

The SHP is subrogated to your rights against a liable third party to the extent of benefits paid for medical expenses. In cases where your injury was the result of a third party, the Plan will seek compensation for medical expenses from the third party who caused the injury. If you receive payment for these medical expenses from another person, firm, corporation or business, you agree to reimburse the Plan in full for any medical expenses paid by the Plan. If you settle a Workers' Compensation claim with your employer, the SHP will not pay benefits for your medical care. If you need more information, please contact your benefits office or EIP.

At Age 65

You should be notified of Medicare entitlement by the Social Security Administration three months in advance of reaching age 65 or at the time of entitlement due to disability. If not, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A and Part B start automatically. If you're not receiving Social Security, you should sign up for Medicare close to your 65th birthday, even if you aren't ready to retire.

If You Are an Active Employee

If you're actively working and/or covered under a state health plan for active employees, you do not need to sign up for Part B because your insurance as an active employee remains primary while you are actively working. However, if you are planning to retire within three months of age 65, you should contact Social Security concerning your enrollment options. Keep in mind that when you subsequently retire you should sign up for Part B within 31 days of retirement as Medicare becomes your primary coverage in retirement.

When Coverage Ends

Coverage Termination

Your SHP coverage will end:

- ❖ the last day of the month you terminate your employment;
- ❖ the last day of the month you enter a class of employees not eligible for coverage (for example, a change from full-time to part-time status);
- ❖ the day following your date of death;
- ❖ the date the SHP is terminated for all employees; or
- ❖ if you do not pay the required premium when it is due. (For example; if you are on leave without pay or on COBRA and are paying full cost, you must make a monthly payment.)

Dependent coverage will end:

- ❖ the date your coverage ends;
- ❖ the date dependent coverage is no longer offered by the State Health Plan; or
- ❖ the last day of the month your dependent is no longer eligible for coverage.

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree or survivor, or under COBRA.

If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

If You Are on Leave Without Pay

You can continue your coverage for up to 12 months if you are on leave without pay, as long as you pay the required premiums. Leave of absence must be approved by your employer or must be a result of injury or sickness (*for information on Family and Medical Leave, contact your benefits administrator*).

COBRA

COBRA is short for the Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of group insurance coverage be offered to you and your covered dependents if you are no longer eligible for coverage under this Plan.

You can continue your coverage for a limited time under COBRA if you and/or your covered dependents lose coverage because:

- ❖ your working hours are reduced from full-time to part-time;
- ❖ you voluntarily quit work, are laid off or fired (unless the firing is due to gross misconduct);
- ❖ you are a separated or divorced spouse; or
- ❖ you are no longer eligible as a dependent child.

It is your responsibility to notify your benefits office within 60 days of the date you become divorced or separated, or the date your dependent child becomes ineligible for coverage.

To continue coverage under COBRA, you must complete and return an NOE to EIP within 60 days of the loss of coverage or notification of the right to continue coverage, whichever is later.

Coverage will not be released for claims payment until premiums are paid. If you need more information about COBRA, contact your benefits office or EIP.

Conversion

The Health Insurance Portability and Accountability Act of 1996 guarantees that persons who have exhausted COBRA benefits and are not eligible for coverage under another group health plan, have access to health insurance coverage without being subjected to a pre-existing condition exclusion period, assuming that certain conditions have been met. In South Carolina, this guarantee of health insurance coverage is provided by the South Carolina Health Insurance Pool. For information regarding this coverage, call 800-868-2500, ext. 42757, or 803-788-0500, ext. 42757, in Columbia.

Death of an Employee or Retiree

In the event of the death of an active employee, you as a surviving family member should contact the deceased's employer to report the death, terminate the employee's health coverage and initiate survivor coverage (if applicable). In the event of a retiree's death, you should contact EIP.

Survivors

If you are a covered spouse or child of a deceased employee or deceased retiree covered by the Plan, you can continue your SHP coverage. In fact, if you are classified as a survivor, your Plan premium will be waived for the first year after the employee's or retiree's death.

This waiver applies to survivors of employer-funded employees and employer-funded retirees only. After the first year, you must pay the full premium to continue coverage. If you and your spouse are both state employees or retirees at the time of death, the surviving spouse is not eligible for the waiver of premium benefit.

If you are the survivor of an active or retired employee, you must contact EIP to enroll. Coverage is not automatic. However, if you and/or your dependent children are covered at the time of the death of the employee or retiree, your coverage will be continued automatically. Eligible surviving spouses and children are enrolled under the retiree group. Refer to the Retiree Section for information.

If you are a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

Survivors of Employees Killed in the Line of Duty

If you are a covered spouse or dependent child of a covered employee, who is/ was killed in the line of duty after Dec. 31, 2001, and while working for an employer participating in the state insurance program, your health insurance premium will be waived for the first year after the employee's death. Following the one-year waiver, you may continue coverage, *at the employer-funded rate*, as long as eligible. Note: If the employer of the covered deceased individual is a local subdivision that does not provide an employer contribution toward retiree insurance coverage, you may continue coverage, at the full rate, as long as eligible.

